Children's Neurology Services

Fax: 03 91258910
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EEG REQUEST FORM

Patient Name	
DOB	
Gender	
Address	
Parent/Guardian name	
Parent/Guardian mobile/email*	

Service required*
Routine EEG ☐ Sleep deprived EEG ☐ Ambulatory 24 hrs EEG ☐

Home Video-EEG Monitoring (HVEM): ☐ 2 nights ☐ 3 nights

Indication for HVEM: characterising events/seizures ☐ Seizure localisation ☐
Assess response to treatment ☐ Subclinical seizures ☐

Additional patient information*
Standard patient ☐ Complex patient ☐

Clinical details for routine EEG/Event description for Ambulatory or HVEM*

Current medications

Date of last seizure (if known)

Referring Doctor

Full name*

Provider number*

Phone*

Email*

Copies of report to: (if known)